

04-04-05

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IN THE UNITED STATES PATENT AND TRADEMARK OFFICE

Application of:

FEUER, Donald S.

Serial No.: 09/479,736

Filed: January 7, 2000

METHOD AND APPARATUS FOR
INTERFACING A PUBLIC SWITCHED
TELEPHONE NETWORK AND AN
INTERNET PROTOCOL NETWORK FOR
MULTI-MEDIA COMMUNICATION

Docket No. CEN2-BH43

Group Art Unit No.: 2662

Examiner: PEZZLO, John

#17

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OFFICE OF PETITIONS

Commissioner For Patents
Alexandria, VA 22313-1450

**PETITION FOR REVIVAL OF AN APPLICATION ABANDONED UNAVOIDABLY
UNDER 37 C.F.R. 1.131(a)**

The above-identified application became abandoned on May 12, 2003, for failure to timely respond to a final Office Action dated February 12, 2003. Applicant hereby requests that the above-identified application be revived pursuant to 37 C.F.R. 1.131(a), or in the alternative, 37 C.F.R. 1.131(b).

A grantable petition under 37 C.F.R. 1.131(a) requires: (1) a petition fee; (2) a reply; and (3) an adequate showing of unavoidable delay. No terminal disclaimer is required for this petition as the above-referenced application was filed after June 8, 1995.

1. The Petition Fee

Included herewith is the small-entity petition fee of \$250.00, as required by 37 C.F.R.

1.17(l). Applicant claims small entity status.

2. The Reply

Included herewith is a Request for Continued Examination (RCE), the appropriate
04/04/2005 SLUANG1 00000003 09479736
01 FC:2452 250.00 OP

RCE fee, a Rule 131 declaration, and an Amendment responsive to the February 12, 2003, Office Action.

3. Adequate Showing of Unavoidable Delay

Included herewith are a Showing of Unavoidable Delay, provided on additional sheets, and accompanying Exhibits that demonstrate unavoidable delay by the Applicant from the due date of the reply, May 12, 2003, to the filing date of this grantable petition.

Applicant additionally states that the entire delay in filing the requested reply from the due date for the required reply until the filing of a grantable petition was unintentional. Thus, Applicant alternatively requests that the above-referenced application be revived pursuant to 37 C.F.R. 1.131(b) as authorized by MPEP 711.03(c)(2).

Applicant has provided in this Petition or enclosed herein the elements required to revive an application abandoned for failure to respond to an Office Action as stated in 37 C.F.R. 1.131(a), or in the alternative, 37 C.F.R. 1.131(b). Thus, Applicant respectfully requests that the above-identified application be revived and issued. Should any questions remain, please do not hesitate to contact the undersigned at 1-800-445-3460. Any additional fees which may be due in connection with this Petition, including any additional fee required under 37 C.F.R. 1.131(b), should be applied against our Deposit Account No. 19-0522.

Respectfully submitted,

HOVEY WILLIAMS LLP

By: 

Thomas B. Luebbering
2405 Grand Boulevard, Suite 400
Kansas City, Missouri 64108
(816) 474 - 9050

ATTORNEYS FOR APPLICANT(S)



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Alexandria, VA 22313-1450

SHOWING OF UNAVOIDABLE DELAY AS REQUIRED BY 37 C.F.R. 1.131(a)

The following showing of unavoidable delay accompanies a Petition for Revival of an Application Abandoned Unavoidably Under 37 C.F.R. 1.131(a). Exhibits 1 and 2 are also included herewith as evidence. This showing is signed below by the Applicant, Mr. Donald S. Feuer, as presenter of the following facts.

1. Applicant's unavoidable delay in prosecuting the application from the date of abandonment, May 12, 2003, to October 7, 2004, was the result of prolonged, serious, and debilitating illness. Specifically, Applicant suffered from a severe form of Crohn's disease, which prevented Applicant from engaging in any form of mental or physical activity, such as employment, leisure activity, or providing information and documents to his agents or attorneys regarding the above-referenced application.

2. Exhibit 1 evidences Applicant's debilitating illness. Specifically, Exhibit 1 is two signed and dated Consent to Surgery forms and hospital receipts outlining various surgical procedures performed on Applicant during late 2002, such as a continued hospitalization, biopsy, colonoscopy, polypectomy, esophagogastroduodenoscopy, and flourscopy, in an attempt to treat Crohn's disease.

3. From the period subsequent to the extensive medical procedures evidenced by Exhibit 1

until October 2004, Applicant was under continuous treatment for Crohn's disease, which included periods of ingesting powerful prescribed pain killers and associated periods of physical and mental rehabilitation and recovery.

4. From the period beginning October 7, 2004, to the filing date of the accompanying grantable petition to revive, Applicant's unavoidable delay in prosecuting the application was the result of inability to locate an agent or attorney to revive and prosecute the application.

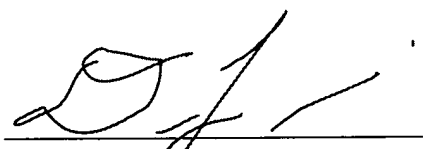
5. Exhibit 2 evidences Applicant's inability to locate a patent agent or attorney. Specifically Exhibit 2 is a record of email correspondence between Applicant and various patent agents and attorneys beginning October 7, 2004, that evidences Applicant's diligent and continuous efforts to revive the application after his prolonged illness.

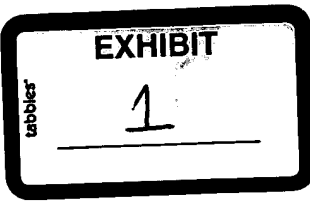
6. Applicant met with his present counsel in late February 2005, who diligently and timely prepared the accompanying petition to revive and other required documents.

7. Applicant additionally states that the entire delay in filing the requested reply from the due date for the required reply until the filing of a grantable petition was unintentional based upon the factual information provided above and enclosed herewith.

8. Applicant further declares that all statements made herein of his own knowledge are true and all statements made on information and belief are believed to be true.

Dated: 3/31/05


Donald S. Feuer

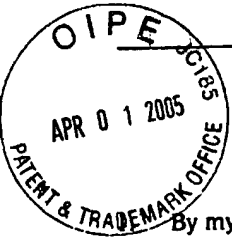


MISSION HOSPITAL REGIONAL MEDICAL CENTER
(949) 364-1400 • (949) 582-2300

Children's Hospital at Mission
(949) 347-8400

27700 Medical Center Road • Mission Viejo, California 92691

TEMPORARY RELEASE FOR TRANSFER TO ANOTHER FACILITY



By my signature below, I give permission to be transferred from the hospital for the performance of a medical procedure(s)

at _____ from _____ to _____
[NAME OF RECEIVING FACILITY] [DATE(S)] [DATE(S)]

and from _____ to _____, as
[APPROXIMATE TIME] [APPROXIMATE TIME]

ordered by _____ M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

2. By my signature below, I hereby authorize _____
[NAME OF TRANSFERRING HOSPITAL]

and _____
[NAME OF RECEIVING FACILITY]

to exchange information and medical records specified below for the purpose of providing services and medical treatment.

Any and all information, including that contained in my/the patient's medical record, may be released unless it is subject to the following restrictions:

[SPECIFY RESTRICTIONS, IF ANY, ON THE INFORMATION WHICH MAY BE RELEASED]

3. My signature below constitutes my acknowledgement that (1) I have read and agree to the foregoing; (2) that the plans for my/the patient's transfer and the procedure(s) to be performed following the transfer have been adequately explained to me by my/the patient's physician; (3) that I have received all of the information I desire concerning such plans and procedure(s); and (4) that I consent to my/the patient's transfer to the facility named above for the performance of the medical procedure.

Date: 8/3/02

Time: 9:15 AM

Signature: [Signature]

[PATIENT/PARENT/CONSERVATOR/GUARDIAN]

If signed by other than patient, indicate relationship: _____

Witness: _____

TEMPORARY RELEASE FOR
TRANSFER TO ANOTHER FACILITY

AUTHORIZATION FOR RELEASE
OF INFORMATION

27700 Medical Center Road • Mission Viejo, California 92691

RADIOLOGY

Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures

To Donald Feuer
Name of Patient

Your attending physician is Dr. Farmanaz Kaidon, M.D.

Your supervising physician J.S. BELVILLE, D.L. RANDALL, W.F. VELICK, S.L. ZIDE, E.J. WAGNER, R.M. TURNER, A.E. STAUFFER, F.H. BURBANK

or surgeon is _____, M.D.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment and this form is not a substitute for such explanations which are provided by the above-named physicians. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent to or refuse any proposed operation or procedure anytime prior to its performance.
2. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event of any emergency causing his or her absence, a qualified substitute supervising physician or surgeon to be selected by your attending physician) together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Mission Hospital Regional Medical Center/Children's Hospital at Mission to whom the supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital or your supervising physician or surgeon but are independent contractors, and therefore your agents, servants or employees.
3. The hospital pathologist is hereby authorized to use his or her discretion in disposition of any member, organ or other tissue removed from my person during the above-named procedure(s).
4. While a patient at Mission Hospital Regional Medical Center/Children's Hospital at Mission, an authorized member of the medical staff or any representative thereof, may photograph me or any part of my body for purposes directly related to the medical care rendered.
5. Your signature below constitutes your acknowledgment (1) that you have read and agree to the foregoing; (2) that the operation or procedure set forth below has been adequately explained to you by your supervising physician or surgeon and by your anesthesiologist and that you have received all of the information you desire concerning such operation or procedure; and (3) that you authorize and consent to the performance of the operation or procedure.

Operation or Procedure

Magnetic Resonance Imaging

of the brain with and without

8/3/02
Date

Signature Jotheim Feuer - wife
Patient / Parent / Legal Guardian

0910
Time

D. Chisell RW
Witness

If signed by other than patient, indicate relationship:

MISSION HOSPITAL REGIONAL MEDICAL CENTER
(949) 582-2300 • (949) 364-1400

Children's Hospital at Mission
(949) 347-8400

27700 Medical Center Road • Mission Viejo, California 92691

RADIOLOGY

Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures

To Donald Fever
Name of Patient

Your attending physician is Dr. Jaramaz Kordon, M.D.
Your supervising physician J.S. BELVILLE, D.L. RANDALL, W.F. VELICK, S.L. ZIDE, E.I. WAGNER, R.M. TURNER, A.E. STAUFFER, F.H. BURBANK

or surgeon is _____, M.D.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment and this form is not a substitute for such explanations which are provided by the above-named physicians. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent to or refuse any proposed operation or procedure anytime prior to its performance.
2. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event of any emergency causing his or her absence, a qualified substitute supervising physician or surgeon to be selected by your attending physician) together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Mission Hospital Regional Medical Center/Children's Hospital at Mission to whom the supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital or your supervising physician or surgeon but are independent contractors, and therefore your agents, servants or employees.
3. The hospital pathologist is hereby authorized to use his or her discretion in disposition of any member, organ or other tissue removed from my person during the above-named procedure(s).
4. While a patient at Mission Hospital Regional Medical Center/Children's Hospital at Mission, an authorized member of the medical staff or any representative thereof, may photograph me or any part of my body for purposes directly related to the medical care rendered.
5. Your signature below constitutes your acknowledgment (1) that you have read and agree to the foregoing; (2) that the operation or procedure set forth below has been adequately explained to you by your supervising physician or surgeon and by your anesthesiologist and that you have received all of the information you desire concerning such operation or procedure; and (3) that you authorize and consent to the performance of the operation or procedure.

Operation or Procedure Spine Biopsy

8/3/02
Date

0910

D. Amis Time
Witness RW

Signature

Kathleen Fever
Patient / Parent / Legal Guardian

If signed by other than patient, indicate relationship:

wife

27700 Medical Center Road • Mission Viejo, California 92691

RADIOLOGY

Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures

To Donald Fuen
Name of Patient

Your attending physician is Dr. Jaraman Kardan, M.D.
Your supervising physician J.S. BELVILLE, D.L. RANDALL, W.F. VELICK, S.L. ZIDE, E.J. WAGNER, R.M. TURNER, A.E. STAUFFER, F.H. BURBANK

or surgeon is _____, M.D.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic and therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure. You have the right to be informed of such risks as well as the nature and purpose of the operation or procedure and the available alternative methods of treatment and this form is not a substitute for such explanations which are provided by the above-named physicians. Except in cases of emergency, operations or procedures are not performed until the patient has had the opportunity to receive such explanations. You have the right to consent to or refuse any proposed operation or procedure anytime prior to its performance.
2. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, such operations or procedures, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event of any emergency causing his or her absence, a qualified substitute supervising physician or surgeon to be selected by your attending physician) together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Mission Hospital Regional Medical Center/Children's Hospital at Mission to whom the supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital or your supervising physician or surgeon but are independent contractors, and therefore your agents, servants or employees.
3. The hospital pathologist is hereby authorized to use his or her discretion in disposition of any member, organ or other tissue removed from my person during the above-named procedure(s).
4. While a patient at Mission Hospital Regional Medical Center/Children's Hospital at Mission, an authorized member of the medical staff or any representative thereof, may photograph me or any part of my body for purposes directly related to the medical care rendered.
5. Your signature below constitutes your acknowledgment (1) that you have read and agree to the foregoing; (2) that the operation or procedure set forth below has been adequately explained to you by your supervising physician or surgeon and by your anesthesiologist and that you have received all of the information you desire concerning such operation or procedure; and (3) that you authorize and consent to the performance of the operation or procedure.

Operation or Procedure Lumbar Puncture by Fluoroscopy

8/3/02

Date

0910

Time

D. Christ RW

Witness

Signature

Kathleen Fuen

Patient / Parent / Legal Guardian

If signed by other than patient, indicate relationship:

wife

MISSION HOSPITAL REGIONAL MEDICAL CENTER
(949) 364-1400 • (949) 592-2300

Children's Hospital at Mission
(949) 347-8400

27700 Medical Center Road • Mission Viejo, California 92691

**AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL
DIAGNOSTIC OR THERAPEUTIC PROCEDURES**

Your attending physician is Kardan, F. To Feuer, Donald ^{Name of Patient} Mary, M.D.
Your supervising physician is RO And, M.D.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. This form is not a substitute for such explanations which are provided by the above-named physicians. You also have the right to be informed whether your physician has an independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or refuse any proposed operation or procedure at any time prior to its performance. To make sure that you fully understand the operation or procedure your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have any questions you are encouraged and expected to ask them.

2. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, this operation or procedure, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Mission Hospital Regional Medical Center/Children's Hospital at Mission to whom the supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital or your supervising physician or surgeon. They are independent contractors, and therefore are your agents, servants or employees.
3. By your signature below you authorize the pathologist to use his or her discretion in the disposition or use of any member, organ or other tissue removed from your person during the operation(s) or procedure(s) set forth below.
4. During this procedure an authorized member of the medical staff or any representative thereof, may photograph you or any part of your body for purposes directly related to the medical care rendered.
5. During this procedure a product representative may be present. The product representative will not assist in the procedure.
6. Your signature on this form indicates (1) that you have read and understood the information provided in this form, (2) that the operation(s) or procedure(s) set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation(s) or procedure(s) and (5) that you authorize and consent to the performance of the operation(s) or procedure(s).

Operation(s) or Procedure(s): **COLONOSCOPY WITH POSSIBLE BIOPSY, DILATATION, BLEEDING CONTROL, AND/OR POLYPECTOMY. CONSCIOUS SEDATION.**

8/9/02 ^{Date}
0545 ^{Time}
Vicky Canje ^{Witness}

Signature [Signature] ^{Patient / Parent / Legal Guardian}
If signed by other than patient, indicate relationship:

MISSION HOSPITAL REGIONAL MEDICAL CENTER
(949) 364-1400 • (949) 592-2300

Children's Hospital at Mission
(949) 347-8400

27700 Medical Center Road • Mission Viejo, California 92691

**AUTHORIZATION FOR AND CONSENT TO SURGERY OR SPECIAL
DIAGNOSTIC OR THERAPEUTIC PROCEDURES**

13732102 KO, ANDREW C. MD
6/02 MR 600116 SDC
03/26/03 39Y M MCS
HLAP

To _____
Name of Patient

Your attending physician is Dr. KO, M.D.

Your supervising physician is _____, M.D.

1. The hospital maintains personnel and facilities to assist your physicians and surgeons in their performance of various surgical operations and other special diagnostic or therapeutic procedures. These operations and procedures may all involve risks of unsuccessful results, complications, injury, or even death, from both known and unforeseen causes, and no warranty or guarantee is made as to result or cure.

You have the right to be informed of such risks as well as the nature of the operation or procedure, the expected benefits or effects of such operation or procedure, and the available alternative methods of treatment and their risks and benefits. This form is not a substitute for such explanations which are provided by the above-named physicians. You also have the right to be informed whether your physician has an independent medical research or economic interests related to the performance of the proposed operation or procedure. Except in cases of emergency, operations or procedures are not performed until you have had the opportunity to receive this information and have given your consent. You have the right to consent to or refuse any proposed operation or procedure at any time prior to its performance. To make sure that you fully understand the operation or procedure your physician will fully explain the operation or procedure to you before you decide whether or not to give consent. If you have any questions you are encouraged and expected to ask them.

2. Your physicians and surgeons have recommended the operations or procedures set forth below. Upon your authorization and consent, this operation or procedure, together with any different or further procedures which in the opinion of the supervising physician or surgeon may be indicated due to any emergency, will be performed on you. The operations or procedures will be performed by the supervising physician or surgeon named above (or in the event that the physician is unable to perform or complete the procedure, a qualified substitute supervising physician or surgeon), together with associates and assistants, including anesthesiologists, pathologists and radiologists from the medical staff of Mission Hospital Regional Medical Center/Children's Hospital at Mission to whom the supervising physician or surgeon may assign designated responsibilities. The persons in attendance for the purpose of performing specialized medical services such as anesthesia, radiology or pathology are not agents, servants or employees of the hospital or your supervising physician or surgeon. They are independent contractors, and therefore are your agents, servants or employees.
3. By your signature below you authorize the pathologist to use his or her discretion in the disposition or use of any member, organ or other tissue removed from your person during the operation(s) or procedure(s) set forth below.
4. During this procedure an authorized member of the medical staff or any representative thereof, may photograph you or any part of your body for purposes directly related to the medical care rendered.
5. During this procedure a product representative may be present. The product representative will not assist in the procedure.
6. Your signature on this form indicates (1) that you have read and understood the information provided in this form, (2) that the operation(s) or procedure(s) set forth below has been adequately explained to you by your physician, (3) that you have had a chance to ask questions, (4) that you have received all of the information you desire concerning the operation(s) or procedure(s) and (5) that you authorize and consent to the performance of the operation(s) or procedure(s).

Operation(s) or Procedure(s): **ESOPHAGOGASTRODUODENOSCOPY WITH POSSIBLE BIOPSY, DILATATION, BLEEDING CONTROL, AND/OR POLYPECTOMY. CONSCIOUS SEDATION.**

August 26, 2002
Date
0850
Time
Dr. [Signature]
Witness

Signature [Signature]
Patient / Parent / Legal Guardian
If signed by other than patient, indicate relationship:

* MEDICATIONS

☐ None

	Name	Dose	When to Take	Reason for Medication	Medication Teaching Monograph given
1	Asa 400	4	3 times	g - 1 tonight	<input type="checkbox"/>
2	MS contin	30mg	T every 2 hours	in pain	<input type="checkbox"/>
3	may take	1/2		only if needed	<input type="checkbox"/>
4					<input type="checkbox"/>
5					<input type="checkbox"/>
6					<input type="checkbox"/>
7					<input type="checkbox"/>

PAIN CONTROL PLAN

"Effective Pain Control While You Heal" pamphlet

Krames "Understanding Your Pain" booklet

☐ Pamphlet given

☐ Booklet given

At home, I will take the following medicines for pain control:

Name	Dose	When to Take	Medication Teaching Monograph given
			<input type="checkbox"/>
			<input type="checkbox"/>
			<input type="checkbox"/>

Nondrug pain control methods:

Constipation is a very common problem when taking narcotic medications. When this happens, do the following:

- ☐ Increase fluid intake (8 to 10 glasses of fluid per day).
- ☐ Exercise regularly.
- ☐ Increase fiber in your diet (bran, fresh fruits, vegetables).
- ☐ Other _____

Call your doctor immediately if your pain increases or if you have new pain. Also call your doctor early for a refill of pain medications. Do not let your medicines get below three or four days' supply.

NUTRITION-DIET

ACTIVITY

ADDITIONAL INSTRUCTIONS

Important: Call Physician for a Fever of _____ ° Orally

given today - Papi 20mg
at 11:00 + Papi 10mg at 11:00
Patch (Vicodin)
Patch at 1320
No 6 at 1330

* MEDICAL FOLLOW-UP

Physician: Stoecker Physician: _____
Date of appointment: Monday Date of appointment: _____
Phone #: 432-4444-583-1600 Phone #: _____
Physician signature: _____ Date: _____

Discharge via: _____ To: Taxi/Car/Amb/Helicopter Patient accompanied by: _____
Valuables envelope ☐ Medications retained in Pharmacy returned ☐ Closet/cubicle empty ☐ Glasses ☐ Wheelchair ☐ Cane ☐
Crutches ☐ Walker ☐ Dentures ☐ Hearing aid(s) ☐
I HAVE RECEIVED AND UNDERSTAND THE ABOVE INSTRUCTIONS:

* Patient or Parent / Guardian [Signature] Date 1-8-10-02 Nurse discharging patient B. L. H. 1-8-10-02
Date 1-8-10-02 KARDAN, FARAHAT MD Date _____

Mission Hospital
ST. JOSEPH
HEALTH SYSTEM

PHYSICIAN DISCHARGE CARE INSTRUCTIONS

WHITE - Chart, YELLOW - Patient, PINK - Physician

A Ministry of the
Sisters of St. Joseph
of Orange

ADDRESSOGRAPH

08/02/02 MR 600116 IN
DOB 03/26/63 39Y M MCS
HEAP

Statement of Account

Peter M Rothenberg MD Inc
653 CAMINO DE LOS MARES
SUITE 105
SAN CLEMENTE, CA 92673
(949) 489-9039

DON FEUER
10 VIA TUNIS
SAN CLEMENTE, CA 92672

FEUER0000

1

12/12/2002

Date	For	Description	Ref	Charges	Credits
09/06/2002	DON	CONSULTATION - IH/SNF L5	13807	325.00	
11/07/2002	DON	NOTATION	13807		0.00
09/06/2002	DON	DETENTION TIME - INPT. FIRST	13807	250.00	
09/06/2002	DON	EKG INTERPRETATION	13807	35.00	
09/07/2002	DON	HOSPITAL CARE - F/U L3	13807	375.00	
09/09/2002	DON	DETENTION TIME - INPT. FIRST	13807	250.00	
09/10/2002	DON	HOSPITAL CARE - F/U L3	13807	125.00	
09/10/2002	DON	DETENTION TIME - INPT. FIRST	13807	250.00	
09/11/2002	DON	HOSPITAL CARE - F/U L3	13807	125.00	
09/12/2002	DON	HOSPITAL CARE - D/C PLANNING	13807	175.00	

0 - 30 Days Current	31 - 60 Days Past Due	61 - 90 Days Past Due	91 - 120 Days Past Due	> 120 Days Past Due	Balance Due
\$1910.00	\$0.00	\$0.00	\$0.00	\$0.00	\$1910.00

Notes

PROMPT PAYMENT APPRECIATED.\$5.00 MONTHLY BILLING FEES START AT 30 DAYS

~~[REDACTED]~~ ink
~~[REDACTED]~~
[REDACTED] [REDACTED]
~~(61) - [REDACTED]~~

~~CONFIDENTIAL~~

100/100

Patient: FEUER, DON Date: 7/02
Physician Ordering Transfer: [Signature]
Physician Accepting Patient: _____
Receiving Facility: _____
Diagnosis: _____
Reason for Transfer: _____
Vital Signs on Transfer: Time _____ P _____ R _____ BP _____ T _____
Patient's Condition: ☒ Stable ☐ Unstable ☐ Critical ☐ Serious ☐ Fair
Transport Mode: ☒ Ambulance ☐ ACLS ☐ Paramedic ☐ Private ☐ Other
Copied: ☒ Nursing notes ☒ Treatment Record ☐ Face Sheet ☒ ECG/LAB/X-RAYS
☒ Personal Effects Sent ☒ Next of Kin Notified
☒ Hospital Notified Report given to: _____ Time _____

PHYSICIAN CERTIFICATION: RISKS AND BENEFITS:

I hereby certify that, based on the examination and information available to me at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical care at another medical facility outweigh the increased risks involved in the patient's (and in the case of pregnancy, to the unborn child's) transfer process. The risks and benefits of a transfer of the patient include:

Risk: _____
Benefit: _____

Physician Signature: _____ Date: _____ Time: _____

PATIENT TRANSFER ACKNOWLEDGEMENT AND CONSENT:

Transfer of (name of Patient): FEUER, DON
I understand that I have a right to receive medical screening, examination, and evaluation by a physician, or other appropriate personnel, without regard to my ability to pay, prior to any transfer from this hospital and that I have a right to be informed of the reasons for transfer. I acknowledge that I have received medical screening, examination, and evaluation by a physician, or other appropriate personnel, and that I have been informed of the reasons for my transfer, and agree to the necessity of the transfer.

PATIENT REQUEST FOR TRANSFER:

This is to certify that FEUER, DON a patient who has received services in this hospital, is being transferred at the request of the patient (or the patient's legal representative). I acknowledge that I have been informed of the risk and consequences potentially involved in the transfer, the possible benefits of continuing treatment at this hospital, and the alternatives (if any) to the transfer I am requesting. I hereby release the attending physician, and other physicians involved in the patient's care, the hospital and its agents and employees, from all responsibility for any ill effects which may result from the transfer.

Patient or Legal Representative Signature: [Signature] Date: 9/7/02

Witness Signature: [Signature] Time: 8:35

**San Clemente
Hospital & Medical Center**
**PATIENT TRANSFER AND
CERTIFICATION FORM**

654 Camino de los Mares
San Clemente, CA 92673

PATIENT LABEL

E MR# 261-618
FEUER, DON 09/07/2002
30Y M 03/26/1962
GENTILE, JOHN F
1557560 0000 E EMR

SAN CLEMENTE HOSPITAL & MEDICAL CENTER

FACILITY - Pink



From: Bill Nieman [bnieman@kmob.com]
Sent: Thursday, October 07, 2004 7:59 PM
To: 'Don Feuer'
Subject: RE: patent attorney recommendation

I am out of the office the rest of the week. I'll plan to call you next week. Look forward to talking to you. Bill

-----Original Message-----

From: Don Feuer [mailto:dfeuer@cox.net]
Sent: Thursday, October 07, 2004 1:39 PM
To: bnieman@kmob.com
Subject: FW: patent attorney recommendation

-----Original Message-----

From: Don Feuer [mailto:dfeuer@cox.net]
Sent: Thursday, October 07, 2004 1:35 PM
To: bneiman@kmob.com
Subject: patent attorney recommendation

Dear Bill,

You were recommended to me by Mike Hudgens (our pastor at Vineyard) in regards to a patent that I have pending. You may recall that I was the one who had Crohn's disease which basically put me out of commission for quite a while. I was the one who was healed in the hospital.

I developed some voice over ip applications a number of years back, and am looking for an attorney whom I can work with to both get the patent process rolling again (I had discussed this with the patent office), and also to prosecute the patent as well as to file other patents.

Please call me at 949-279-5290 so that we could potentially get together to discuss these areas.

Sincerely,

Don Feuer

"<KMOB.COM>" made the following annotations.

From: Aaron Barker [abarker@kmob.com]
Sent: Thursday, November 04, 2004 2:08 PM
To: dfeuer@cox.net
Cc: Bill Nieman; Amy Perez
Subject: Contact at Patent Office



USPTO
Contacts.pdf

Don,

I look forward to our phone call this afternoon at 4:00.

As you recall, we discussed possibly calling the Patent Office to ask what kind of documentation we would need to provide to revive your application. You gave us with a list of several individuals (see the attached pdf file) at the Patent Office. Is there a particular individual from the attached list that you would like us to contact? It appears that you may have left a message with Shalima Grant. Did this individual ever return your message?

Sincerely,

Aaron D. Barker
Knobbe, Martens, Olson & Bear, LLP
2040 Main Street, 14th Floor
Irvine, California 92614
Main (949) 760-0404
Direct (949) 721-2942
FAX (949) 760-9502
abarker@kmob.com
FEUER.001A

<<USPTO Contacts.pdf>>

"<KMOB.COM>" made the following annotations.

From: Bill Nieman [bnieman@kmob.com]
Sent: Friday, November 05, 2004 5:44 PM
To: dfeuer@cox.net
Subject: Emailing: search_detail.html

Don, one of my partners thought this guy would be a good possibility (I know nothing about him). This same partner was also very complimentary of Ray Hom.

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T.J. Singh
Member

Klein, O'Neill & Singh, LLP

2 Park Plaza, Suite 510
Irvine, California 92614
(Orange Co.)

Telephone: 949-955-1920

Fax: 949-955-1921

Email: [Send an Email](#)

Practice Areas: Intellectual Property

Admitted: 1996, California; registered to practice before U.S. Patent and Trademark Office

Law School: Loyola Law School, J.D., 1996

College: Institute of Technology, B.H.U., India, B.Tech., 1985;
California State University, Long Beach, M.S., 1991

Member: American Intellectual Property Law Association; Orange County Patent Law Association (Director).

Languages: Hindi and Punjabi

Born: Allahabad, India, 1963

ISLN: 913916122

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3/24/2005

From: Bill Nieman [bnieman@kmob.com]
Sent: Friday, November 05, 2004 5:53 PM
To: dfeuer@cox.net
Subject: patent atty
One more name:

Glenn R. Smith
28626 Brookhill Road
Trabuco canyon, Ca 92679

949-709- 7164

I know Glenn personally (nice guy), but have not worked with him. Others speak well of him. He's a solo practitioner (thus, maybe less expensive), an EE, but I think Ray Hom would have the best technical background of those suggested so far. When you decide who you want to start with, let me know and I'll call them to let them know that you'll be calling. Bill

Knobbe, Martens, Olson & Bear, LLP
2040 Main Street, 14th Floor
Irvine, CA 92614
Telephone: 949/760-0404
Fax: 949/760-9502
E-Mail: wnieman@KMOB.com
www.KMOB.com

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=====

From: Aaron Barker [abarker@kmob.com]
Sent: Tuesday, November 16, 2004 4:49 PM
To: 'don feuer'
Cc: Bill Nieman; Amy Perez
Subject: Return of your file

Don,

I understand that you will be having a meeting tomorrow in our building around 2:30 p.m. If you would like, I can return your file to you at that time. Just ask for me at the 14th floor reception area and I will bring you the file.

If this does not work for you, please let me know and we can make other arrangements.

Sincerely,

Aaron D. Barker
Knobbe, Martens, Olson & Bear, LLP
2040 Main Street, 14th Floor
Irvine, California 92614
Main (949) 760-0404
Direct (949) 721-2942
FAX (949) 760-9502
abarker@kmob.com

FEUER.000GEN

"<KMOB.COM>" made the following annotations.

--

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From: Bill Nieman [bnieman@kmob.com]
Sent: Thursday, December 02, 2004 6:00 PM
To: dfeuer@cox.net
Subject: Emailing: attorneys.html

here is the last name I have. As discussed I do not have a basis for recommending him, but you may want to talk to him. Bill



Providing intellectual property counsel to the high technology sector.

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PATENT AGENTS

PATENT ENGINEERS

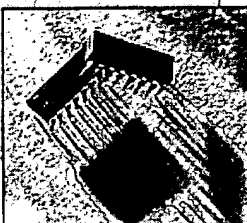
PARALEGALS/STAFF

RECRUITING

Robert F. Gazdzinski Managing Partner, Gazdzinski & Associates

Mr. Gazdzinski is registered to practice before the U.S. Patent and Trademark Office, and has been admitted to the State Bars of California, New Jersey, and Pennsylvania. He has also been admitted to United States District Courts for the Southern District of California, District of New Jersey, and Eastern District of Pennsylvania.

Mr. Gazdzinski has a Juris Doctor degree from Rutgers University School of Law, a Master of Business Administration (MBA) from University of San Diego, and a Bachelor of Science in Physics from Drexel University. Mr. Gazdzinski has also completed the Naval Nuclear Power Training program (comparable to a Master's degree in nuclear engineering).



Prior to forming his own firm, Mr. Gazdzinski was associated with the law firm of Knobbe, Martens, Olson and Bear in San Diego, CA for several years. While at Knobbe Martens, Mr. Gazdzinski was responsible for domestic and international patent and trademark prosecution for a number of clients, as well as directing two patent evaluation and acquisition projects relating to a wide spectrum of technologies including asynchronous transfer mode (ATM), IEEE 802.3x, IEEE 1149 JTAG, virtual private networking (VPN), speech recognition, IS-95, IS-54/136, GSM/PCS-1900, CDPD, IEEE 802.11 WLAN, FHSS, ITU H.323, MPEG, and digital signal processing (DSP). Mr. Gazdzinski also negotiated and drafted software licenses for a variety of clients.

Before joining Knobbe Martens, Mr. Gazdzinski was an extern with the New Jersey Corporation for Advanced Technology, a senior nuclear engineer with *Ogden Corporation*, a Naval Officer assigned to nuclear submarines and naval intelligence, and a semiconductor research technician with *IBM Corporation* at Brookhaven National Laboratory. Mr. Gazdzinski also worked as an operations assistant at Peach Bottom Atomic Power Station.

Mr. Gazdzinski is sole inventor on five (5) issued U.S. Patents, and several pending applications. He has also published several works relating to intellectual property and various topics relating to nuclear engineering and electrical/electronics component aging, including SAND-96-0344, which is currently used by the U.S. Nuclear Regulatory Commission as a licensing standard for nuclear plant electrical components (see IEEE-Std. 1205-2000). He is also member of the American Intellectual Property Law Association, American Nuclear Society, and other professional organizations.

From: Bill Nieman [bnieman@kmob.com]

Sent: Tuesday, December 28, 2004 1:04 PM

To: 'Don Feuer'

Subject: RE: Emailing: attorneys.html

sorry, I was out yesterday. are you available tomorrow to have lunch with me and my partner, Jerry Sewell (I mentioned to you that he is leaving the firm)?

From: Don Feuer [mailto:dfeuer@cox.net]

Sent: Monday, December 27, 2004 9:06 AM

To: 'Bill Nieman'

Subject: RE: Emailing: attorneys.html

Hey Bill,

Merry Belated Christmas... Would you like to get together today for lunch?

Don

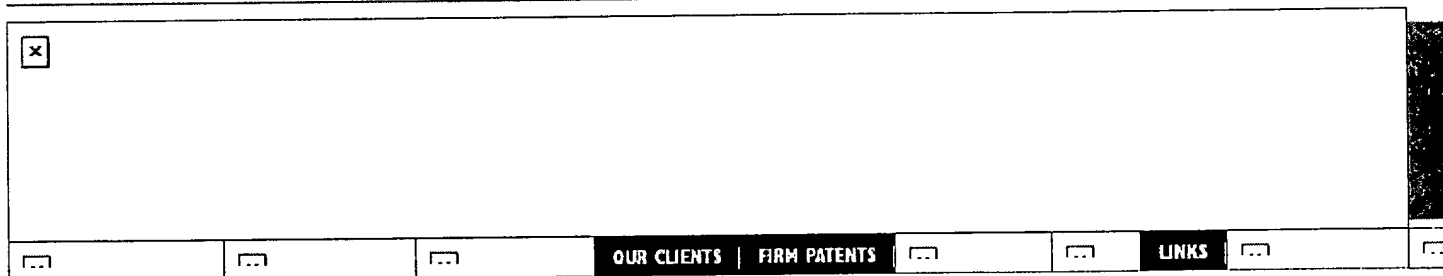
From: Bill Nieman [mailto:bnieman@kmob.com]

Sent: Thursday, December 02, 2004 4:00 PM

To: 'dfeuer@cox.net'

Subject: Emailing: attorneys.html

here is the last name I have. As discussed I do not have a basis for recommending him, but you may want to talk to him. Bill



OUR PERSONNEL

	Robert F. Gazdzinski
	Managing Partner, Gazdzinski & Associates
	Mr. Gazdzinski is registered to practice before the U.S. Patent and Trademark Office, and has been admitted to the State Bars of California, New Jersey, and Pennsylvania. He has also been admitted to United States District Courts for the Southern District of California, District of New Jersey, and Eastern District of Pennsylvania.
	Mr. Gazdzinski has a Juris Doctor degree from Rutgers University School of Law, a Master of Business Administration (MBA) from University of San Diego, and a Bachelor of Science in Physics from Drexel University. Mr. Gazdzinski has also completed the Naval Nuclear Power Training program (comparable to a Master's degree in nuclear engineering).

Prior to forming his own firm, Mr. Gazdzinski was associated with the law firm of Knobbe,

From: Robert Gazdzinski [rob@gazpat.com]
Sent: Monday, December 20, 2004 5:29 PM
To: dfeuer@cox.net
Cc: Carrie DeCoro
Subject: FW: recommendation by Bill Nieman

Dear Don:

Thanks for contacting us regarding this matter. Unfortunately, I think we'll have to decline for two reasons; (i) we are completely overloaded and not taking any new clients for the foreseeable future; and (ii) we have done a good deal of VoIP/SIP/H.323 work for various clients to date, and hence it is quite likely that we'd have a subject matter conflict for handling your application.

I'll try asking around to see if I can't come up with a good recommendation for you; however, everyone I know is also blocked up and not taking new clients.

Sorry I can't be of more help. If you have questions, please advise.

Best regards,
Rob

Robert F. Gazdzinski
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-----Original Message-----

From: Don Feuer [mailto:dfeuer@cox.net]
Sent: Monday, December 20, 2004 12:27 PM
To: ipdomestic@earthlink.net
Subject: recommendation by Bill Nieman

Dear Mr. Gazdzinski,

Bill Nieman from KMOB requested that I contact you regarding a patent that I have pending regarding voip applications. The firm of KMOB ended up having a conflict of interest whereby they had to drop me as a client.

The patent was filed in early 2000 and due to illness was abandoned with cause, thereby it needs to be reactivated with an attorney whom does not have a conflict in this area.

Could you please give me a call at 949-279-5290 to discuss this further?

Sincerely,

Don Feuer